Foundation *for* Opioid Response Efforts

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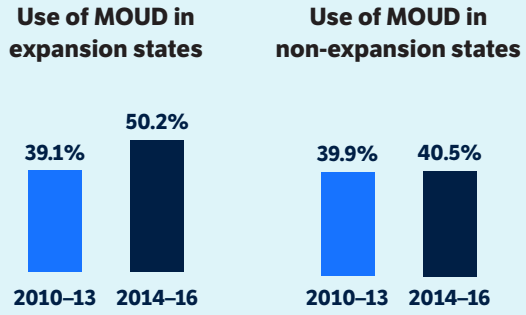
Issue Brief

Leveraging Medicaid Policy to Enhance Access to Opioid Use Disorder Treatment

INTRODUCTION

Medicaid is the single largest payer for opioid use disorder (OUD) treatment, covering **nearly 40 percent** of non-elderly adults who sought treatment in 2017. In states that have expanded Medicaid coverage to more low-income adults, more people now have access to medications for opioid use disorder (MOUD), the standard of treatment.

In states that expanded Medicaid, use of MOUD increased significantly among people diagnosed with OUD



Source: Ramin Mojtabai et al., "Affordable Care Act and Opioid Agonist Therapy for Opioid Use Disorder," *Psychiatric Services* 70, no. 7 (July 2019): 617-20.

Medicaid can be a lifeline for groups who often face significant barriers to accessing OUD treatment, including low-income youth, pregnant and parenting people, justice-involved populations, and communities of color. FORE has committed more than $10 million to expand access to treatment for these populations. Some grants are to researchers who are analyzing Medicaid claims data to better understand disparities in access to care and treatment outcomes, as well as the effects of changes in state policies designed to address them. FORE grantees are also identifying programs tailored to the needs of Medicaid beneficiaries and opportunities to expand them.

EXPANDING ACCESS TO TREATMENT IN PRIMARY CARE

With FORE support, researchers at Rutgers University have been studying the impact of changes in New Jersey's Medicaid policies that aim to enhance access to MOUD in primary care. Nearly two-thirds of people seeking treatment for substance use disorders in New Jersey are covered by Medicaid.

TAKEAWAYS

1 The expansion of Medicaid has increased access to treatment for OUD, including medications for opioid use disorder, in many states.

2 FORE grantees are studying the impact of expansion and other Medicaid policy changes — helping to shine a light on remaining gaps in care and opportunities to intervene.

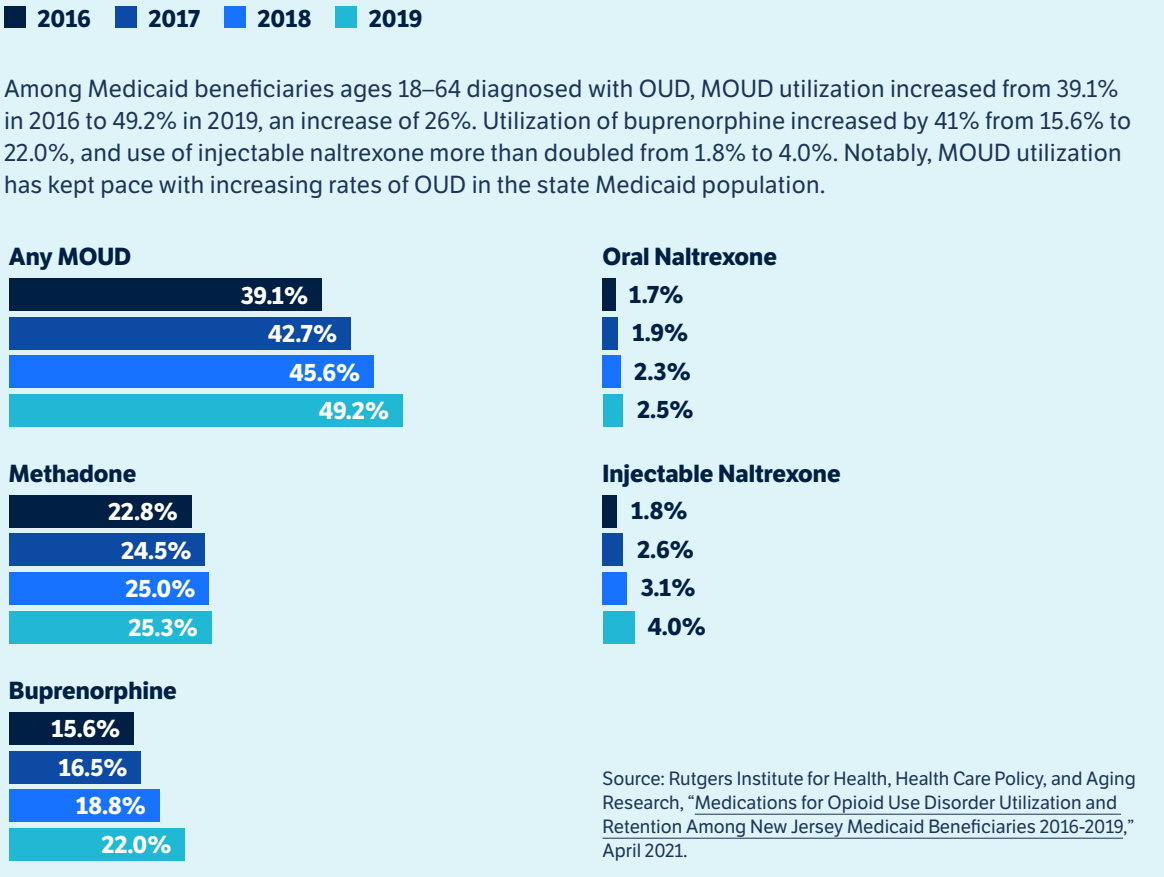
3 FORE grantees are also identifying programs tailored to the needs of Medicaid beneficiaries and opportunities to expand them.

Starting in 2019, the state has sought to increase access to buprenorphine by eliminating prior authorization requirements and raising reimbursement levels for office-based providers. Clinicians can now earn up to $438 for medical intake appointments. Primary care providers can also bill for peer support and patient navigation services that help keep patients in treatment; **research has shown** that people who stay in treatment longer have better outcomes. Through the state's MATRx program, primary care providers who are prescribing MOUD can also consult with addiction medicine specialists at two medical schools.

To evaluate the impact of these policy changes, Stephen Crystal, Ph.D., and his colleagues are analyzing Medicaid claims data and interviewing treatment providers as well as patient navigators, Medicaid officials, and staff at managed care plans. Their **early findings** suggest MOUD initiation increased from 2016 to 2019 among beneficiaries who received an OUD diagnosis or survived an overdose, and that disparities in access to buprenorphine by race are beginning to close.

However, qualitative interviews with providers suggest the impact of removing prior authorization requirements in 2019 was blunted by other health plan restrictions on MOUD prescribing such as formulary preferences and safety audits. Explicit guidance issued by the state in April 2020 that directed health plans to pay for generic forms of MOUD, including buprenorphine up to 32 milligrams a day, may help overcome those impediments, the researchers say. They have also found that more providers are billing for OUD intake appointments, but not as many are billing for navigation services. This may be because many practices face challenges in staffing these positions and credentialling navigators so that their services can be reimbursed.

MOUD utilization among beneficiaries diagnosed with OUD, 2016–2019



Among Medicaid beneficiaries ages 18–64 diagnosed with OUD, MOUD utilization increased from 39.1% in 2016 to 49.2% in 2019, an increase of 26%. Utilization of buprenorphine increased by 41% from 15.6% to 22.0%, and use of injectable naltrexone more than doubled from 1.8% to 4.0%. Notably, MOUD utilization has kept pace with increasing rates of OUD in the state Medicaid population.

Source: Rutgers Institute for Health, Health Care Policy, and Aging Research, "Medications for Opioid Use Disorder Utilization and Retention Among New Jersey Medicaid Beneficiaries 2016-2019," April 2021.

While the Rutgers researchers are still collecting and analyzing data from 2020, early indications suggest the number of primary care providers offering MOUD is still well below what is needed. The state may need to consider other strategies for encouraging primary care practices to treat patients with OUD, including anti-stigma campaigns, provider training, or start-up funding to help practices hire navigators.

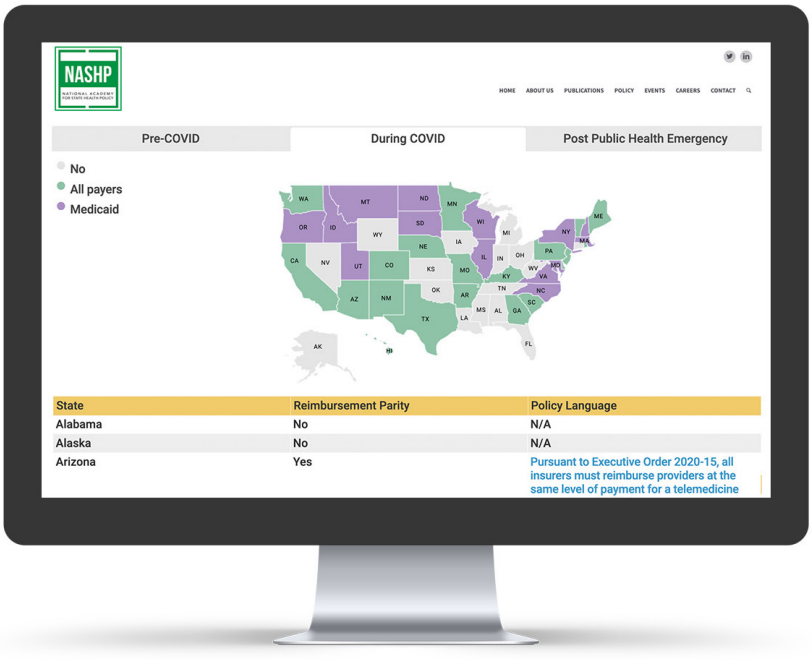
CONVENING STATE LEADERS TO FIND SOLUTIONS

With FORE funding, the National Academy for State Health Policy (NASHP) created the **State Policy Center for OUD Treatment and Access** to share effective strategies and track changes in Medicaid policies and other state regulations, including those introduced during the pandemic to enhance access to treatment and harm reduction services.

Several states have adopted payment parity for telehealth to promote uninterrupted access to OUD treatment and some states have gone further by helping providers adopt telehealth technology. Washington State, for instance, bought hundreds of Zoom licenses for Medicaid providers. To support states interested in replicating successful approaches, NASHP developed a **toolkit** that includes model legislative, regulatory, and budgetary approaches and examples for states.

NASHP also serves as a convenor of state policymakers navigating the opioid crisis. Many face challenges managing multiple funding streams involved in their opioid responses and coordinating the work of agencies that have jurisdiction over OUD prevention and treatment — from Medicaid to criminal justice and education.

The organization's goal is to help states find solutions with the resources they have. Toward that end, NASHP has profiled work in states that have and have not expanded Medicaid to more low-income residents. For example, leaders in Alabama, which has not expanded Medicaid, are relying on block grants to support crisis intervention programs that divert people with substance use disorders (SUDs) from emergency departments and jails and into treatment. Maryland, an expansion state, has leveraged Medicaid funding as well as grants to offer treatment and wraparound supports — including counseling, housing, employment, and peer supports — to parents with SUD who are at risk of losing their children.



The National Academy for State Health Policy tracks the policy and reimbursement changes states are employing to address the opioid crisis — from requiring payment parity for telehealth services to increasing access to harm reduction services.

Source: **https://www.nashp.org/opioid-center/expanding-services-during-covid-19/#toggle-id-2**

NASHP's work has been guided by a steering committee that includes representatives from state behavioral health departments, state Medicaid agencies, a drug court judge, and the substance use disorder coordinator for a corrections department, among others. Members met monthly at the height of the pandemic to talk through the challenges of modifying Medicaid policies, such as waiving urine drug screenings and counseling requirements for patients receiving MOUD. These temporary changes, designed to protect patients and providers during the pandemic, have given states an opportunity to reimagine SUD treatment, including delivering services via telehealth. "Many states have made telehealth payment parity for SUD services permanent and have invested in telehealth infrastructure for patients and providers," says Jodi Manz, M.S.W., a project director with NASHP's Chronic and Vulnerable Populations team. "They're also considering how to use federal funds for things like mobile crisis intervention and home- and community-based services to support SUD treatment services."

BRINGING TREATMENT TO PEOPLE IN THE CRIMINAL JUSTICE SYSTEM

The Legal Action Center (LAC), another FORE grantee, is investigating ways to expand access to MOUD and other needed SUD care in jails and prisons, where they estimate between 50 percent and 75 percent of people have a history of SUD and at least 15 percent have an OUD.

Few states mandate that corrections facilities provide incarcerated people with OUD with access to MOUD; **Maryland**, **New York**, **Rhode Island**, and **Vermont** are exceptions with policies designed to strengthen access. "The norm is very poor care behind the walls," says Gabrielle de la Guéronnière, LAC's policy director.

Both funding and stigma against MOUD are deterrents, she says. The Medicaid Inmate Exclusion Rule prevents states from using Medicaid dollars to pay for care inside of prisons and jails, leaving states to finance care themselves. Several states are seeking Section 1115 waivers from the Centers for Medicare and Medicaid Services that would allow them to use Medicaid funds to pay for discharge planning, medications, and linkage to community-based providers in the last 30 days of an individual's incarceration.

LAC is offering guidance to state and federal policymakers interested in leveraging Medicaid initiatives, funding, and tools such as Section 1115 waivers to provide these re-entry supports for incarcerated people with OUD. In a letter to the administrator of the Centers for Medicare and Medicaid Services, LAC outlined several steps the agency could take to improve screening for SUD and enhance access to treatment for those involved in the legal system. More than 50 national, state, and local stakeholder groups signed on.

Since 2014, dozens of states have taken advantage of Medicaid expansion to **connect people leaving incarceration** with OUD treatment and recovery services. Some states now suspend rather than terminate Medicaid coverage upon incarceration, so detainees can quickly reactivate coverage upon release. Without such systems in place, there can be gaps in coverage as people transition back into the community — a time when people with OUD are at **heightened risk** of overdose.

"The good thing is that states are very interested in making addiction treatment for people in the criminal legal system work better," de la Guéronnière says. "There's an understanding that this would help in a number of different directions — from reducing recidivism to promoting public health and racial justice and equity."

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> – **Gabrielle de la Guéronnière, Legal Action Center policy director**

POLICY IMPLICATIONS

Medicaid is the chassis on which much of the nation's OUD treatment system is built. In states that have not expanded their Medicaid programs, some clinicians and treatment programs struggle to reach all who need services. In North Carolina, a non-expansion state, FORE grantees are developing a "hub-and-spoke" system to encourage primary care providers to offer OUD treatment. Clinicians at the "hubs" — University of North Carolina at Chapel Hill and the Mountain Area Health Education Center (MAHEC), an academic health center based in Asheville — are lending oversight and support to 13 community health centers and two health departments (the "spokes"). "Expanding access to evidence-based treatment and prevention services is critical for ending this crisis," says Shuchin Shukla, M.D., M.P.H., a family physician and opioid educator at MAHEC. "In North Carolina, where we have not expanded Medicaid, public funds are being spent on the opioid crisis for emergency rooms, ambulances, jails, and prisons. This is a costly and ineffective approach in terms of lives lost, community safety, and actual dollars spent."

Even without expansion, Medicaid agencies have a range of options to lower barriers to treatment, for example by eliminating prior authorization requirements for MOUD and limiting drug testing requirements imposed on patients.

States can also leverage waiver authorities to provide coverage for people coming out of jail and prisons and can tap other resources, including monies made available for crisis response efforts and extended postpartum benefits through the American Rescue Plan Act.

Additionally, Medicaid programs can shape the delivery system for OUD treatment and recovery services by offering incentives for infrastructure, such as telehealth equipment, and by paying for wraparound services including those provided by peer recovery coaches. Medicaid programs could also create quality standards for OUD treatment and track performance.

"Continued tracking of the impact of these various policies on access and equity will be critical to establishing what works and why for a large share of the U.S. population who receives treatment through Medicaid," says Karen Scott, M.D., M.P.H., FORE's president.

FORE

FORE is a national, private, grantmaking foundation focused on inspiring and accelerating action to end the opioid crisis.

We are committed to convening and supporting partners advancing patient-centered innovative, evidence-based solutions to make the greatest impact on the crisis.

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